Section 2
Narrative and Checklist

Narrative

General Considerations

Current Direction

During the last quarter century the provision of health care to veterans has changed dramatically. When initially developed, the care for veterans was episodic and inpatient oriented. Changes in health care delivery have resulted in a shift of care to the outpatient arena with an emphasis on continuity of care. To facilitate these changes the concept of Community Based Outpatient Clinics (CBOC) has been developed. It is projected that with the coming of health care reform (if not on a national level but on a state by state level) the need for these clinics will increase.

A Community Based Outpatient Clinic is a full time/part time ambulatory care facility that is physically separate, but administratively attached to a VA Medical Center. The clinic is a simple physician's office that provides primary care. Typically this care would consists of:

- Initial assessment of patient needs;
- Acute and chronic basic care of biopsychosocial needs;
- Health promotion and disease prevention; and
- Referral for other levels of care.

Administratively the clinics would be under the supervision of the ACOS/Ambulatory Care or the person designated to be the supervisor of primary care. Periodic visits from the clinical and administrative chiefs at the parent facility would be made to ensure quality care was being delivered.

Future Trends:

As health care changes, the need for conveniently accessible clinics will grow. It is anticipated that in order to compete with the private sector the VA will have to locate clinics close to where the veterans live. This will result in more CBOC's in diverse areas away from the parent facility. With the interdisciplinary nature of primary care more of these clinics will need to be established utilizing a variety of providers including physicians, physician assistants, nurse practitioners, nurse clinical specialists, social workers and others. It is anticipated that these clinics will provide the basics of care for the patient population that they are following. More sophisticated testing and consultations will be referred to the parent facility. An integral part of the concept of primary care is the provision for the biopsychosocial needs of the patient care and his/her family. The CBOC should be set up in a manner that will facilitate meeting this need.

Potential developments in National Health Care Reform may dictate that the VA will not only care for the veteran but also for her/his family. It is planned all veterans will be able to utilize VA facilities under the new health care plan. The number of veterans this could potentially involve is in excess of 26 million with more than 356 million visits per year.

The VA currently employs five types of clinics, excluding CBOC's, these are:

1. *Outpatient Clinic* - The most traditional of the VA clinics that is associated with and located within a medical center.

2. *Satellite Outpatient Clinics* - These clinics are associated with a medical center administratively but are at some distance from the medical center. There are distance guidelines used in determining the location of such clinics.

3. *Community Based Clinics* - These are smaller clinics with set criteria for their establishment. Community Based Clinics are associated administratively with a medical center.

4. *Outreach Clinics* - These clinics have a definite function and plan to reach out to a specific group of patients. Outreach Clinics are associated with a medical center administratively.

5. *Independent Clinics* - These are large clinics located in the metropolitan area that do not have a medical center. They function administratively as separate entities from any medical center.

It is planned the new CBOC's will be set up on the basis of a planned number of visits per year. At this time 3,000, 7,000 or 15,000 outpatient visits per year have been suggested. There is NO distance requirement between the Community Based Outpatient Clinic and the medical center.

Leasing:

The VA has been leasing space for clinics since it received delegation from GSA in 1984 to do so. Some of these leases may take up more than a year to complete. In order to provide medical centers and other independent facilities an opportunity to obtain leased space for the Basic Module CBOC's in a timely manner, the VA has instituted an expedited leasing procedure. To qualify for this procedure, a clinic must require no more space or medical buildout than is set forth within the Basic Module. Otherwise, the standard procedure requiring the issuance of a Solicitation for Offers must be used. In either process, care should be taken to avoid listing of VA-provided, VA-installed items which do not require any action on the part of the lessor and are likely to confuse him/her with their presence.

Functional Considerations:

Vicinity Relationships

In the development of a Community Based Outpatient Clinic, it is extremely important the clinic can compete with other medical facilities in the area. The location and the surrounding area become very important aspects in the overall success of the clinical program. Locate the clinic in a neighborhood with prime commercial office building space or in a research, clinical or technology space that is suitable for the specific medical purpose. The neighborhood should present a professional image and offer a feeling of security for patients and personnel.

Site Characteristics

The site should offer prominent visibility and have dominant ingress/egress accessibility to major highways and public transportation for ease of commuting for staff and patients. A circuitous route through an unsightly neighborhood is undesirable. The site should provide flexibility to accommodate the proposed building, ample parking for its intended use, and well defined traffic patterns. The site should present an attractively landscaped, well-maintained environment that screens noise and unsightly views. The topography should reflect a generally flat nature with no steep grades so people with disabilities can easily traverse the site or access the building. Verify that the site has good drainage and is not impacted by the 100 year flood plain.

Building Orientation

Orient the clinic so the main entrance faces and is visible from a major highway or access road and be clearly identified. Locate any of the maintenance-type areas (trash, delivery, or service) in the rear of the building away from the main entrance.

Parking

Locate patient parking spaces as close as possible to the accessible clinic entrance and to an accessible walk serving this entrance. Avoid using ramps if possible. If the clinic is located in a shopping mall, provide clear signage from the parking area to the clinic.

ARCHITECTURAL ASPECTS:

Siting:

Location of clinics in areas of greatest need is a leading concern. Clinics should be located in areas where access problems prevent veterans from obtaining needed care at a VAMC.

Hospitals are generally not the best place to locate primary care facilities. Most hospitals are in or near city centers, while the population continues to move to the outskirts. Many private sector primary care facilities are being located near existing ambulatory care centers for easy access for both patients and physicians.

The clinic's various departments can be tailored to meet the needs of the community. In order to support the facility, there should be sufficient veteran population within 35 miles (or 50 miles in more rural areas) of the clinic. Facility staff also need sufficient access to the clinic and the Medical Center, as the workload may be shared among the clinic and medical center staff. In urban settings, CBOC's reduce the outpatient load that the medical center experiences. Veterans receive direct care at the CBOC, and need only go to the medical center in emergency situations.

Except in large cities, where the only way to build is up, new primary care facilities usually are being spread out horizontally. Elevators are not the most convenient way for delivering services in a cost-effective way or for the patient and families to access services.

In order to compete with the private sector through the National Health Plan, primary care clinics must be designed to take into account the patients personal and private surroundings.

SPACE PLANNING:

Functional space requirements for VA clinics are based on leasing space. A full time clinic operates 5 days per week, 8.5 hours each day. To determine the appropriate space program, staffing projections by personnel category, and projected total outpatient visits per year must be estimated.

CBOC's should be designed in a series of single function spaces. The spaces that comprise a CBOC are as follows: waiting areas, reception area, interview room, medical record storage, x-ray storage, a fee basis station, staff offices, exam rooms, blood specimen room, screening room, consultation room, multipurpose procedure room, clean and soiled utility rooms, and supply storage areas. Support services (laboratory, pharmacy, and radiology services) will take place at the VAMC or on a contract basis.

Storage needs extend beyond dedicated storage rooms. Each exam room requires storage for linens, supplies, and refuse.

The patient sequence in a primary care clinic is similar to a private doctor's office. In general, the patient checks in with the Medical Administrative Service (MAS) at the reception desk, may be interviewed by a nurse, visits with provider, and checks out with the nurse and MAS.

Modular Design:

Considering the increased focus on primary care, a large portion of the space needs to be planned for this purpose. There is a need, however, for multifunctional space where specialty clinics meet less than daily and the space is used for several types of clinics.

Accessibility:

Public Law 90-480 requires all construction, renovation, or leasing with federal funds to meet Uniform Federal Accessibility Standards (UFAS).

Patient Privacy:

The Department of Veterans Affairs has interpreted JCAHO requirements in the area of patient privacy and has stated that “auditory and visual privacy during treatment” should be provided.

Cost:

Satellite structures have lower building requirements than do hospitals and therefore, substantially lower initial first cost. Check your local applicable codes for the appropriate occupancy for your project

INTERIOR DESIGN:

Interior design includes the concept for the interior space, space planning, lighting, noise control, privacy issues, safety, wayfinding systems includes signage, furnishings, and finish selections including attributes of color and texture among others. In formulating the concept, consider users, their age, who, if any one, accompanies the veterans, staff, geographical location, weather, and the building, if applicable. In waiting areas, find out if T.V. is to be used. If so, when considering conversational groups for seating, have some orientated to the T.V. set. Add music to mask sounds, and green plants for life. Consider using carpet for noise reduction. The color scheme should be appropriate to the times, place, and possibly, the building. It should be an integral part of a consistent and coordinated wayfinding scheme which is applied to the entire CBOC. Remember, with time, room and department designations might change. Finishes and furnishing are to meet commercial, safety and health care codes as well as health concerns, (e.g. No slick, high gloss flooring materials).

The environment needs to be one that appropriately supports the patient, physicians, staff and the community. The design must relate and help define the term "high-quality care". The design, therefore, must balance technological needs and human needs.

Expressing the local regional elements in the design, materials, colors, textures and patterns is a good start towards patient and staff comfort and satisfaction with the environment.

Color, texture and pattern needs to be thought of as a psychological and physical tool. It can outline, emphasize, alert, neutralize or camouflage. Bright values like stark white are not a good choice they cause reflection, glare and telescope dirt and scuff marks. Avoid dark saturated colors that create holes and voids for the elderly, visually compress the space and absorb lumens. Accent colors, textures and patterns need to be provided to offer relief, interest and help with the users orientation of building.

A "wayfinding" or cueing system in coordination with signage, that begins with the parking or drop-off area and takes the person through the building, is essential for orientation. It needs to incorporate the building's elements such as color, texture, pattern, artwork, and lighting into the system. The signage must coincide with what the staff calls each space and move people in the traffic patterns that the facility desires.

Parking:

Patient parking should be located as close as possible to the clinic entrance. If the clinic is located in a shopping mall, then there should be clear signage from the parking area to the clinic.

SUPPORT AREAS:

Laboratory:

Pathology and Laboratory Service has introduced an innovative, cost-efficient/cost effective concept in the delivery of outpatient care called Mobil Lab™. Mobil Lab™ is specifically designed to meet both patient and health care provider needs in an outpatient care setting such as the Community Based Outpatient Clinic. Mobil Lab™ is a small self-contained laboratory testing unit capable of being moved to points within a hospital, clinic or outpatient areas to expedite the delivery of point-to-care testing. Mobil Lab™ is adaptable to both routine and emergency use and provides limited testing for basic chemistry, hematology, coagulation toxicology and urinalysis test most often needed for daily patient monitoring and STAT use. The lab is operated by a medical technologist who will offer a menu of clinically important tests required for immediate case management decisions. Mobil Lab™ result reporting will rapidly provide the care giver with a permanent record of the capability of down-loading information into DHCP on a daily basis.

The impact of Mobil Lab™ on day to day operations of the CBOC will include: (a) reducing the cost of medical care by shortening the therapeutic turnaround time of laboratory results, (b) making test results available at the time and place when therapeutic decisions need to be made, (c) allowing health care managers the opportunity to make more efficient use of medical staff, (d) lowering direct cost of operations, (e) placing immediate test results thus eliminating long delays, and (g) saving physician's, nurses and allied health personnel time because a certified medical technologist now performs patient screenings, monitors results of a patient's therapy, and provides emergency testing for patients needing urgent care.

Mobil Lab™ will require only one room (200 NSF) and an associated cabinet and counter top and a sink (see CBOC Guide Plate 5-4). No other special design features will be required. With Mobil Lab™, the CBOC will more than likely not have to send out patient specimens to either a local referenced lab or to the nearest VA medical center, if the most common range of laboratory tests have been ordered.

Pharmacy:

Pharmacy Service in a Community Based Outpatient Clinic will reflect the changes in VA Health Care to primary care. Emphasis will be placed on the provision of medical care as part of an interdisciplinary team. Pharmacists on the team will stress provision pharmaceutical care including drug therapy monitoring and patient education. Provision of prescriptions will be supported through electronic communications with a primary medical facility and establishment of contract relationships (PPO, Fee for Service) with community pharmacies.

Prescriptions generated by the Community Based Outpatient Clinic will be provided in a number of ways. Each Community Based Outpatient Clinic will be supported by a main medical facility or a Consolidated Mail Outpatient Pharmacy (CMOP). The small (basic) to medium size clinic will provide a consultation room for pharmacy and a minimum storage area for initial supplies of pharmaceuticals. After providing patient consultation on new prescriptions, the pharmacist will enter prescription data into a DHCP terminal for transmission to the main medical facility or CMOP. The pharmacist may provide an initial supply of medications to the patient or direct the patient to a contracted pharmacy for medications required immediately. Refills will be handled by mail from the main medical facility.

Large (expanded) Community Based Outpatient Clinics will have a free standing pharmacy. This pharmacy can provide a greater number of services but is designed smaller than the pharmacies at Medical Centers. In addition to the required patient consultation on new prescriptions, the large pharmacy will provide the initial supply of medications. Refill requests will be handled by the clinic but may be filled by remote CMOPs. The size of the pharmacies is dependent on the establishment of electronic communication with all VA medical facilities. VA pharmacies will have the ability to share prescription data on patients treated at medical facilities throughout the VA health care system.

Radiology:

Cost benefit analysis must be performed to determine the feasibility of providing in-house diagnostic radiological services verses contracting for these services in the community and/or referral to other VA facilities. Comparisons of availability of services, initial cost of space, equipment, equipment maintenance, recurring costs of staff, supplies and utilities should be considered.

If in-house diagnostic radiological services are justified, use of teleradiology with transmission of images to the parent VAMC should be considered to reduce or eliminate the need for costly physician radiologist staff.

Technical Considerations:

Electrical:

Not available at this time.

Heating, Ventilating, and Air Conditioning:

Provide air conditioning system to heat, cool, and ventilate the individual spaces, and comply with the VA HVAC Design Manual For Hospital Projects. The facility is not intended to operate 24 hours a day, therefore, the HVAC system must have flexibility to operate at reduced capacity during the unoccupied hours.

Provide air economizer cycle with return air fans for air handling units except in high humidity areas where use of economizer cycle may increase overall building energy use.

The number of people and the air conditioning loads noted on the room design standard sheets must be verified for a special project. The data shown is for purpose of establishing the basis of design guide and its use in planning.

Plumbing:

Domestic hot, cold water and sanitary sewer shall be provided to adequately serve the plumbing fixtures required.

It is recommended that hands free type fixtures (electronic sensor control), be used in patient care areas.

Structural:

In compliance with Executive Order (EO) 12699, and EO 12941, all new and existing buildings constructed or leased by the Federal Government must be seismically safe. The EO's require that nationally recognized model building codes, listed below, be used for the seismic design and construction of new buildings, and for the seismic safety assessment of existing buildings.

- 1991 Uniform Building Code of the International Congress of Building Officials (ICBO).
- 1992 Supplement to the Building Officials and Code Administrators (BOCA) National Building Code.
- 1992 Amendments to the Southern Building Code Congress (SBCC) Standard Building Code.

Community Based Outpatient Clinic Checklist

DRAFT 7-6-95

This checklist is designed to assist those who are in the process of planning a Community Based Outpatient Clinic. Since all projects and sites differ, some items in the checklist might not apply to your particular situation. In addition, conditions might occur that this checklist does not cover. This checklist consist of the following four sections: Accessibility, Interior Finishes, Leasing and Site Considerations.

ACCESSIBILITY

The following checklist has been adopted from the VA's "Barrier Free Design Handbook" H-08-13. It is intended to help identify possible accessibility deficiencies when surveying existing space/site for the use of a Community Based Outpatient Clinic. When UFAS and ADA requirements differ from that of H-08-13 it will be noted in brackets.

Outside Accessibility

1. Walks	YES	NO
a. Free of steps or abrupt changes of level.		
b. Minimum width of 5' -0". [UFAS & ADA 3'-0"]		
c. Maximum gradient of 1:33 (otherwise considered a ramp). [UFAS & ADA 1:20]		
d. Cross slopes no greater than 1:50.		
e. Walks with gradients of 1:50 to 1:33 have rest areas every 200'. [UFAS & ADA 1:33]		
f. Changes in level are blended to common levels by grading, curb cuts or ramps.		
g. Firm, nonslip surfaces		
h. Free of gratings, manholes, etc.		
i. Level platforms (minimum of 6'-0" x 6'-0") at doors. [UFAS & ADA - 5'-0" x 5'-0"]		

2. Hazards	YES	NO
a. Accessible paths of travel are free of hazardous side protrusions.		

3. Curb Ramps	YES	NO
a. Provide wherever a walk crosses a curb.		
b. Located or protected to prevent obstruction by parked vehicles or street furnishings.		
c. Maximum slope, 1:20 [UFAS & ADA - 1:12.]		
d. Minimum width, 4'-0". [UFAS & ADA - 3'-0"]		
e. Smooth transition from curb ramp to street or grade level.		
f. Firm, slip resistant surface.		

4. Ramps	YES	NO
a. Maximum slope, 1:20. [UFAS & ADA - 1:12]		
b. Slope of 1:33 to 1:24: ramp no greater than 40' in length. [UFAS & ADA - 200' in length ramp]		
c. Slope of 1:25 to 1:20: ramp no greater than 35' in length. [UFAS & ADA - 200' in length ramp]		
d. Cross slope no greater than 1:50.		
e. Minimum clear width, 4'-0". [UFAS & ADA - 3'-0"]		
f. Top and bottom landings are at least 5'0" long.		
g. Intermediate landings at least 35' or 40' intervals are at least 5'0" long.		
h. Where doors swing onto a ramp landing, the landing is level an at least 6'-0" x 6'-0". [UFAS & ADA - 5'-0" x 5'-0"]		
i. Where required, handrails are installed on both sides.		
j. Handrails are mounted at a height of 2'-9" and extend 1'-0" beyond beginning and end of ramp.		
k. Firm, slip-resistant surface.		
l. Ramp curbs are at least 4" high by 4" wide. [UFAS & ADA - 2" high]		

5. Passenger Loading Area	YES	NO
a. In a safe area and clearly designated for passenger arrival and departure.		
b. Close as possible to accessible entrance.		
c. Zoned to prohibit parking.		
d. Ramped to sidewalk level.		
e. Access aisles, measuring at least 5'-0" wide by 20'-0" long and parallel and level with the vehicle pull-up space.		

6. Parking	YES	NO
a. 10% of total number of parking spaces accessible.		
b. Located conveniently to accessible entrances.		
c. Identified by accessibility symbols and routing signage.		
d. Spaces are at least 8'-0" wide with access aisles on each side. [UFAS & ADA - 8'-0" wide with one access aisle per two spaces]		
e. Spaces 11'-0" wide with 5'-0" access aisles for specially adapted vans. [ADA - 8'-0" wide with 8'-0" access aisle]		
f. Access aisles are at least 5'-0" wide with surface slope not exceeding 1:50.		
g. Smooth transition from access aisle to adjacent walkway.		
h. Minimum clear width of adjacent walkways not reduced by vehicle overhang.		

Inside Accessibility

1. Entrances	YES	NO
a. All highly used entrances are accessible.		
b. They are connected by an accessible walk to accessible parking and public streets.		
c. They are connected to all accessible elements (e.g. elevators and ramps) and spaces throughout a building by paths of travel at 3'-8".		
d. Signage at accessible entrances.		
e. Maximum opening force for interior hinged doors is 5lbs.		
f. Thresholds are flush with finished floor or beveled with a slope no greater than 1:2.		
g. Operating devices on doors are easy to operate with one hand.		
h. Knurled surfaces on operating hardware of doors leading to hazardous areas. [ADA - No requirement]		
i. Bottom rail (kickplate) is at least 1'-0" high. [UFAS & ADA - No requirement]		
j. Automatic doors are used in high-use areas.		

2. Floors	YES	NO
a. Firm and slip-resistant surface.		
b. Changes in level between 1/4" and 1/2" are beveled with a slope no greater than 1/2". (Changes in level up to 1/4" require no edge treatment).		
c. Changes in level greater than 1/2" comply with "Ramps".		

3. Carpet	YES	NO
a. Carpet is securely attached and has a low-cut pile and tight weave.		

4. Corridor Handrails	YES	NO
a. 1 1/2" diameter.		
b. 1 1/2" space between handrail and mounting surface.		
c. Height of handrails, 2'-10".		
d. Handrail sections are free of sharp edges.		
e. Wall surfaces behind handrails are smooth.		
f. Ends of hand rails are rounded.		
g. High and low bumperguards in equipment and W/C & Litter storage.		
h. Low bumperguards (just above base) at reception, interview counter & service windows (agent cashier & pharmacy) to protect against W/C footrest.		

5. Doors and Doorways	YES	NO
a. Minimum 2'-10" clear opening to all rooms.(excluding bathrooms. See 7c.) [UFAS & ADA - 2'-8"]		
b. Level approach to doors.		
c. 1'-6" clearance at latch side of all doors.		
d. Minimum clearance between manual doors in series, 4'-0" plus width of the door.		

6. Water Fountains	YES	NO
a. Spout height no higher than 3'-0".		
b. Water fountains usable by the physically handicapped.		

7. Toilet Rooms	YES	NO
a. Public and common use toilet rooms are usable by the physically handicapped.		
b. Signage for accessible toilet rooms.		
c. Minimum width of entrance doors to toilet rooms, 3'-0".		
d. Minimum space between vestibule doors, 4'-0" plus width of the door swinging into space.		
e. Clear turning space of 5'-0".		
f. Minimum clear width of doorways to toilet stalls, 2'-8".		
g. Wheelchair "Side-transfer stall", minimum 5'-6" wide by 5'-0" deep. (2'-8" door swings out) [UFAS & ADA - 5'-0" x 4'-8"]		
h. Wheelchair "front-transfer stall", minimum 3'-0" wide by 5'-6" deep. (2'-8" door swings out) [UFAS & ADA - 3'-0" x 5'-6"]		
i. Water closet, top of rim 18" above finished floor. [UFAS & ADA - 17"-19"]		
j. Urinal basin lip, 15" above finished floor. [UFAS - 17"]		
k. lavatory, minimum underneath clearance of 2'-5".		
l. Faucets easily operated (preferably hands free type for patient care areas).		
m. Mirrors, shelves and dispensers, a maximum height of 3'-4" above finished floor.		
Grab Bars		
a. Grab bars, 33" above finished floor. [UFAS & ADA - 33" - 36"]		
b. 1 1/2" in diameter.		
c. 1 1/2" space between grab bar and mounting surface.		
d. Handrails are free of sharp edges.		
e. Wall surfaces behind grab bars are smooth.		

7. Stairs	YES	NO
General		
a. Minimum width of stairs, 3'-8".		
b. Treads and risers are of uniform size on a single flight of stairs.		
c. Stairways are well illuminated.		
Treads & Risers		
a. Maximum riser height, 7".		
b. Closed risers.		
c. Minimum tread width, 11".		
d. Slip-resistant tread surface.		
e. Nosing neither abrupt or square.		
Handrails		
a. Handrails on both side of stair.		
b. 1 1/2" diameter.		
c. 1 1/2" space between handrail and mounting surface.		
d. Height of handrails, 34". [UFAS & ADA - 30" - 34"]		
e. Handrails are free of sharp edges.		
f. Wall surfaces behind handrails are smooth.		
g. Ends of handrails are smooth.		
h. Handrails extend 1'-0" on one side beyond the top riser and 1'-11" on one side beyond the bottom riser.		
I. Height of guardrail at top of landing, 3'-6".		

8. Elevators	YES	NO
a. In multi-story facilities each level is served by an elevator, interior ramp or platform lift. [ADA - does not require elevators in buildings less than three stories or less than 3,000 square feet per story]		
b. Automatic operation.		
c. Self-leveling plus/minus 1/2".		
d. Minimum clear width of elevator doors, 4'-0". [UFAS & ADA - 3'-0"]		
e. Doors are equipped with safety reopening device.		
f. Minimum car size, 8'-0" x 6'-2". [UFAS & ADA - 68" x 54"]		
g. Auxiliary control panel, centered at 3'-0" above car floor. [ADA - Brailled]		
h. Hall call buttons, centered at 3'-4" above car floor.		
i. Call and operating buttons, raised and illuminated. [ADA - Brailled]		
j. Audible and visual signals operate when car is passing through the floors it serves.		
k. Emergency alarm system.		
l. Intercom system.		
m. Double set of handrails, 2'-8" and 3'-4". [UFAS & ADA - no requirement]		
n. Floor surface of car is firm and slip resistant.		

9. Platform Lifts	YES	NO
a. Capable of safely and comfortably transporting an occupied wheelchair.		
b. Fully operable by wheelchair occupant or aide.		
c. Controls mounted within easy reach and no higher than 3'4".		
d. Clear floor space of 5'-0" x 5'-0" at the point of entrance to and exit from the lift.		

INTERIOR FINISHES

Interiors	YES	NO
a. Design solution is consistent with the interior concept including the users needs.		
b. Design solution reflects state-of-the-art health care design including, but not limited to, color, textures, and patterns.		
c. Materials and finishes meet fire, safety, and accessible codes.		
d. Design projects a high quality of care and caring.		
e. Wayfinding system is developed to satisfy the orientation needs of the first time user.		
f. Signage is a coordinated system and is appropriate, readable, and directive.		
g. Space planning is appropriate to functions.		
h. Lighting is correct for function, users, and users' ages.		
i. Materials are durable and easily maintained.		
j. Noise and privacy issues are addressed.		
k. Furnishings are appropriate for health care functions.		

LEASING

The following checklist was provided by Real Property staff for the purpose of helping the contracting officer and those assisting in the Community Based Outpatient Clinic planning process meet their desired leasing goals.

Leasing	YES	NO
a. Is the extent of the geographical area within which the space is being sought (delineated area) large enough to obtain reasonable competition?		
b. If rural nature of location precludes obtaining such competition, has that fact been set forth fully in a Justification for Other Than Full and Open Competition?		
c. Have you advertised for parties interested in providing the space or alternatively, for space less than 10,000 net usable square feet, have you contacted at least three brokers familiar with commercial property in the delineated area?		
d. Have a parent facility contracting official, engineer and using facility representative undertaken a market survey of each site to determine whether each can or cannot be made to meet VA's requirements within a reasonable time frame?		
e. Does the market survey form for each site which has been determined to be non-solicitable include a very specific reason for this determination, one which cannot be corrected by the offeror?		
f. Has the floorplan for the proposed space been compared to the Basic Module to determine that in order to determine whether the Expedited Leasing Procedure (ELP) is usable? (Extreme caution should be taken in attempting to obtain prompt quotes, the basic element of the ELP for any medical buildout beyond that set forth in the Basic Module.)		
g. Is sufficient narrative and graphic representation of the exact specifications and layout VA requires within the space attached to the form requesting bids to avoid confusion and to assure a contract in which VA obtains fully occupiable space?		
h. Does any confusion arise which seems to require formal negotiations? If so, a cancellation of the Expedited Leasing Procedure should be considered in favor of issuance of a Solicitation for Offers, with negotiations following receipt of the initial offers in order to facilitate the request for best and final offers.		
i. Has the completed space been inspected by a VA contracting official, using official and engineer to assure that all requirements of the contract have been met, to include those of the local building code and VA fire and safety and handicapped accessibility codes?		
j. Is it understood that any changes to the contract once it is executed by both parties, must be set forth and similarly executed on a Supplemental Lease Agreement (GSA Form 276)?		

SITE CONSIDERATIONS

The following checklist is provided to help in the selection of a potential site or examining an existing site for a Community Based Outpatient Clinic.

1. Vicinity Relationships	YES	NO
a. Is the location and surrounding area conducive to a medical care facility?		
b. Does the neighborhood have prime commercial office space or a research, technology, or business park setting that is suitable for medical purpose use?		
c. Does the neighborhood present a professional image and offer a feeling of security for patients or personnel?		

2. Site Characteristics	YES	NO
a. Does the site offer prominent visibility?		
b. Does the site have dominant ingress/egress accessibility to major highways for ease of commuting for staff and patients?		
c. Does the site have dominant ingress/egress accessibility to public transportation for ease of commuting for staff and patients?		
d. Does the site provide flexibility to accommodate the proposed building, parking and vehicular and pedestrian circulation?		
e. Is the site well-maintained and present an attractive landscape that screens noise and unsightly views?		
f. Is the topography generally flat with no steep grades so that people with disabilities can transverse the site and access the building?		
g. Future planned used of adjacent property desirable for a medical clinic?		
h. Does the site have good drainage away from the building?		
i. Is the site impacted by the 100-year flood plain?		

3. Building Orientation	YES	NO
a. Does the main entrance face or is it visible from a major highway or access road?		
b. Are the maintenance-type areas (trash, delivery, or service) located in the rear of the building?		

4. Parking	YES	NO
a. Is the patient parking located close to an accessible entrance or an accessible walk serving this entrance?		
b. Are any ramps necessary to move patients, staff and visitor from the parking area to the building entrance?		
c. If any ramps exist, are they accessible?		
d. Is there clear signage provided from the parking area to the clinic?		